		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042481

Facility Name: ASPEN RIDGE CARE CENTRE

Address: 2530 NORTH MONROE STREET (Number) DECATUR (City) 62526 (Zip Code)

County: MACON

Telephone Number: (847) 875-0920 **Fax #** (847) 876-9351

IDPA ID Number: 36-4121314

Date of Initial License for Current Owners: 02/01/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	204	Skilled (SNF)	195	73,299	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	195	73,299	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,085	1,222	10,689	21,996	8
9	SNF/PED					9
10	ICF	34,120	4,572	4,740	43,432	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,205	5,794	15,429	65,428	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.26%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 204 and days of care provided 8,755

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	246,892	36,258	18,727	301,877		301,877	(292)	301,585			1
2	Food Purchase		246,120		246,120		246,120	(1,578)	244,542			2
3	Housekeeping	247,991	37,106		285,097		285,097	(2,807)	282,290			3
4	Laundry	107,016	16,932	1,747	125,695		125,695	182	125,877			4
5	Heat and Other Utilities			168,332	168,332		168,332		168,332			5
6	Maintenance	63,458	20,965	54,669	139,092		139,092	(337)	138,755			6
7	Other (specify):*			26,214	26,214		26,214		26,214			7
8	**TOTAL General Services**	665,357	357,381	269,689	1,292,427		1,292,427	(4,832)	1,287,595			8
	B. Health Care and Programs											
9	Medical Director			38,400	38,400		38,400		38,400			9
10	Nursing and Medical Records	2,202,838	149,277	22,074	2,374,189		2,374,189	(26,848)	2,347,341			10
10a	Therapy	30,145		48,472	78,617		78,617		78,617			10a
11	Activities	96,612	6,135	10,483	113,230		113,230	(107)	113,123			11
12	Social Services	128,341		3,208	131,549		131,549		131,549			12
13	Nurse Aide Training											13
14	Program Transportation			2,718	2,718		2,718		2,718			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,457,936	155,412	125,355	2,738,703		2,738,703	(26,955)	2,711,748			16
	C. General Administration											
17	Administrative	96,617		664,575	761,192		761,192	(647,002)	114,190			17
18	Directors Fees											18
19	Professional Services			280,596	280,596		280,596	13,104	293,700			19
20	Dues, Fees, Subscriptions & Promotions			106,292	106,292		106,292	(60,307)	45,985			20
21	Clerical & General Office Expenses	201,971	32,219	50,831	285,021		285,021	130,047	415,068			21
22	Employee Benefits & Payroll Taxes			576,427	576,427		576,427		576,427			22
23	Inservice Training & Education			4,665	4,665		4,665		4,665			23
24	Travel and Seminar			1,857	1,857		1,857	12,822	14,679			24
25	Other Admin. Staff Transportation			7,736	7,736		7,736		7,736			25
26	Insurance-Prop.Liab.Malpractice			208,650	208,650		208,650	65,546	274,196			26
27	Other (specify):*			60,382	60,382		60,382	(60,382)				27
28	**TOTAL General Administration**	298,588	32,219	1,962,011	2,292,818		2,292,818	(546,172)	1,746,646			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,421,881	545,012	2,357,055	6,323,948		6,323,948	(577,959)	5,745,989			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: ASPEN RIDGE CARE CENTRE **#0042481** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	18,727	
	REPAIRS & MAINTENANCE		0	
			0	18,727
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,747	
			0	1,747
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		67,569	
	ELECTRICITY		72,819	
	WATER		27,944	
	CABLE TV - LOBBY		0	
			0	168,332
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		15,572	
	PAINTING & DECORATING		2,732	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		18,010	
	ELEVATOR MAINTENANCE & REPAIR		3,495	
	OUTSIDE LABOR		2,496	
	EXTERMINATING SERVICE		6,600	
	FIRE SERVICE		5,764	
			0	
			0	
			0	54,669
7	**OTHER**			
	SCAVENGER		25,291	
	SECURITY SERVICE		923	26,214
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	38,400	38,400

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,670	
	PHARMACY CONSULTANT	XVIII B 39-2	1,200	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	15,707	
	ALZHEIMERS CONSULTANT	XVIII B 46-2	2,497	
		XVIII B 47-2		22,074
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		24,582	
	SPEECH THERAPY SERVICES		1,653	
	OCCUPATIONAL THERAPY SERVICES		22,237	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	48,472
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		7,639	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,844	
			0	10,483
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,208	
			0	3,208
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASPEN RIDGE CARE CENTRE **#0042481** **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		2,718	2,718
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	664,575	664,575
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	37,366	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	243,230	
			0	280,596
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	22,582	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	25,782	
	EMPLOYEE WANT ADS	XIX F	17,335	
	CONTRIBUTIONS	VI 20 XIX F	457	
	DUES & SUBSCRIPTIONS	XIX F	18,256	
	LICENSES & PERMITS	XIX F	6,898	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	11,615	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,483	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,884	106,292
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		3,567	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	11,872	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		564	
	TELEPHONE		30,454	
	MESSENGER SERVICE		4,374	
			0	50,831

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	260,803	
	UNEMPLOYMENT COMPENSATION	XIX D	43,654	
	WORKERS COMPENSATION INSURANCI	XIX D	84,028	
	HOSPITALIZATION INSURANCE	XIX D	172,557	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,683	
	EMPLOYEE PHYSICAL EXAMS	XIX D	6,728	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	3,974	
	CHICAGO HEAD TAX	XIX D	0	576,427
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,665	4,665
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	1,857	
			0	
			0	1,857
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		7,736	7,736
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		208,650	208,650
27	**OTHER**			
	BAD DEBTS	VI 24	60,382	
			0	60,382

GRAND TOTAL COLUMN 3 OTHER 2,357,055

ASPEN RIDGE CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2003

TOTAL FOOD PURCHASE	246,120	PATIENT MEALS	196284
LESS SALES TAX	(1,578)	ADD EMPLOYEE MEALS	0
NET FOOD	244,542	TOTAL MEALS/YEAR	196284
TOTAL PATIENT CENSUS	65,428	NET FOOD	244542
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	196284
TOTAL PATIENT MEALS	196284	COST PER MEAL	1.25
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number ASPEN RIDGE CARE CENTRE #0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			97,205	97,205		97,205	199,166	296,371			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			586,903	586,903		586,903	499,214	1,086,117			32
33	Real Estate Taxes			74,349	74,349		74,349		74,349			33
34	Rent-Facility & Grounds			744,600	744,600		744,600	(724,253)	20,347			34
35	Rent-Equipment & Vehicles			57,215	57,215		57,215	8,578	65,793			35
36	Other (specify):* STORAGE			3,550	3,550		3,550		3,550			36
37	**TOTAL Ownership**			1,563,822	1,563,822		1,563,822	(17,295)	1,546,527			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		233,555	675,826	909,381		909,381		909,381			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,949	109,949		109,949		109,949			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		233,555	785,775	1,019,330		1,019,330		1,019,330			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,421,881	778,567	4,706,652	8,907,100		8,907,100	(595,254)	8,311,846			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(58,033)	30		9
10	Interest and Other Investment Income	(2,579)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,578)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(11,872)	21		18
19	Entertainment	(22,582)	20		19
20	Contributions	(1,940)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,167)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,382)	27		24
25	Fund Raising, Advertising and Promotional	(25,782)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(11,615)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(46,747)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (244,277)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(350,977)	PG 6,6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (350,977)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (595,254)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ASPEN RIDGE CARE CENTRE

ID# 0042481

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 423	6	1
2	VACATION ACCRUAL	(292)	1	2
3	VACATION ACCRUAL	(2,807)	3	3
4	VACATION ACCRUAL	182	4	4
5	VACATION ACCRUAL	(760)	6	5
6	VACATION ACCRUAL	(39,435)	10	6
7	VACATION ACCRUAL	(107)	11	7
8	VACATION ACCRUAL	(3,184)	17	8
9	VACATION ACCRUAL	(767)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(46,747)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(292)	0	0	0	0	0	0	0	0	0	0	(292)	1
2	Food Purchase	(1,578)	0	0	0	0	0	0	0	0	0	0	(1,578)	2
3	Housekeeping	(2,807)	0	0	0	0	0	0	0	0	0	0	(2,807)	3
4	Laundry	182	0	0	0	0	0	0	0	0	0	0	182	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(337)	0	0	0	0	0	0	0	0	0	0	(337)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,832)	0	0	0	0	0	0	0	0	0	0	(4,832)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(39,435)	12,587	0	0	0	0	0	0	0	0	0	(26,848)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(107)	0	0	0	0	0	0	0	0	0	0	(107)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(39,542)	12,587	0	0	0	0	0	0	0	0	0	(26,955)	16
	C. General Administration													
17	Administrative	(3,184)	(643,818)	0	0	0	0	0	0	0	0	0	(647,002)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,167)	7,521	6,750	0	0	0	0	0	0	0	0	13,104	19
20	Fees, Subscriptions & Promotions	(61,919)	1,612	0	0	0	0	0	0	0	0	0	(60,307)	20
21	Clerical & General Office Expenses	(12,639)	142,686	0	0	0	0	0	0	0	0	0	130,047	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,822	0	0	0	0	0	0	0	0	0	12,822	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	6,412	59,134	0	0	0	0	0	0	0	0	65,546	26
27	Other (specify):*	(60,382)	0	0	0	0	0	0	0	0	0	0	(60,382)	27
28	**TOTAL General Administration**	(139,291)	(472,765)	65,884	0	0	0	0	0	0	0	0	(546,172)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(183,665)	(460,178)	65,884	0	0	0	0	0	0	0	0	(577,959)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(58,033)	4,059	253,140	0	0	0	0	0	0	0	0	199,166	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,579)	0	501,793	0	0	0	0	0	0	0	0	499,214	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	20,347	(744,600)	0	0	0	0	0	0	0	0	(724,253)	34
35	Rent-Equipment & Vehicles	0	8,578	0	0	0	0	0	0	0	0	0	8,578	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(60,612)	32,984	10,333	0	0	0	0	0	0	0	0	(17,295)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(244,277)	(427,194)	76,217	0	0	0	0	0	0	0	0	(595,254)	45

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD.		MANAGEMENT/
		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					MORTON GROVE	
				ASPEN RIDGE MONROE STREET, LLC		REAL ESTATE
					MORTON GROVE	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 12,587	$ 12,587	1
2	V	17	ADMINISTRATIVE	664,575	MR. BELLOWS OWNS 62.5% OF THIS FACILITY		20,757	(643,818)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		7,521	7,521	3
4	V	20	DUES & SUBSCRIPTIONS		" "		1,612	1,612	4
5	V	21	CLERICAL		" "		142,686	142,686	5
6	V	24	TRAVEL		" "		12,822	12,822	6
7	V	26	INSURANCE		" "		6,412	6,412	7
8	V	30	DEPRECIATION		" "		4,059	4,059	8
9	V	34	RENT		" "		20,347	20,347	9
10	V	35	RENT-EQUIPMENT & VEH.		" "		8,578	8,578	10
11	V								11
12	V								12
13	V								13
14	Total			$ 664,575			$ 237,381	$ * (427,194)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 744,600	ASPEN RIDGE MONROE STREET, LLC		$	$ (744,600)	15
16	V	26	MORTGAGE INSURANCE		" "		59,134	59,134	16
17	V	30	DEPRECIATION - BLDG/IMPROV.		" "		161,340	161,340	17
18	V	30	DEPRECIATION - EQPT		" "		91,800	91,800	18
19	V	32	AMORTIZATION - MTG COST		" "		4,624	4,624	19
20	V	32	INTEREST - MORTGAGE		" "		494,608	494,608	20
21	V	32	INTEREST - OTHER		" "		2,561	2,561	21
22	V	19	ACCOUNTING FEES		" "		6,750	6,750	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 744,600			$ 820,817	$ * 76,217	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES, INC.								$		1
2	SHAEL BELLOWS	MANGMT. CNSLT.	ADMIN.	62.5%	SEE ATTACHED	3.14	13.24	SALARY	20,757	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 20,757		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES, INC.
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	493,454	9	$ 94,929	$ 94,929	65,428	$ 12,587	1
2	17	ADMINISTRATIVE	PATIENT DAYS	493,454	9	159,981	159,981	65,428	20,757	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	493,454	9	56,724		65,428	7,521	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	493,454	9	12,155		65,428	1,612	4
5	21	CLERICAL	PATIENT DAYS	493,454	9	191,338		65,428	25,369	5
6	21	CLERICAL	DIRECT COST	1	1	117,317	117,317	1	117,317	6
7	24	TRAVEL	PATIENT DAYS	493,454	9	96,702		65,428	12,822	7
8	26	INSURANCE	PATIENT DAYS	493,454	9	48,361		65,428	6,412	8
9	30	DEPRECIATION	PATIENT DAYS	493,454	9	30,611		65,428	4,059	9
10	34	RENT	PATIENT DAYS	493,454	9	153,459		65,428	20,347	10
11	35	RENT-EQUIPMENT & VEH.	PATIENT DAYS	493,454	9	64,696		65,428	8,578	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,026,273	$ 372,227		$ 237,381	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY - ASPEN RIDGE MONROE STREET, LLC						$	$			$	1
2	GMAC		X	MORTGAGE	$46,016.00	07/02	7,480,000	7,399,980	07/2037	6.6600	494,608	2
3	LOAN COSTS		X		AMORT - 35 YEARS		161,845	154,909			4,624	3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BNK		X	WORKING CAPITAL	VARIES		450,000		DEMAND	PRIME+	36,848	6
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES		3,120,000		DEMAND	VARIES	552,616	7
8												8
9	TOTAL Facility Related				$46,016.00		$ 11,211,845	$ 7,554,889			$ 1,088,696	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 11,211,845	$ 7,554,889			$ 1,088,696	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 59,134 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 65,688	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 69,633	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,945	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 70,404	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 74,349	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000	43,338	10
2001	64,976	11
2002	69,633	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASPEN RIDGE CARE CENTRE COUNTY MACON

FACILITY IDPH LICENSE NUMBER 0042481

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-03-251-011	NURSING HOME	$ 139,266.24	$ 69,633.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 139,266.24	$ 69,633.12

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,720 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	90,679		$	1
2					2
3	TOTALS	90,679		$	3

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	195		1996		$ 4,059,452	$ 147,616	27.5	$ 147,616	$	$ 1,027,164	4
5					14,949	544	27.5	544		3,510	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - ASPEN RIDGE MONROE STREET, LLC										9
10	FIRE DOORS/ALUMINUM SCREENS			1997	3,609	131	27.5	131		852	10
11	LANDSCAPING			1997	16,142	587	27.5	587		3,815	11
12	OUTDOOR SIGNS			1997	8,110	295	27.5	295		1,807	12
13	KITCHEN REMODELING - FLOORING/CONCRETE FOOTINGS			1998	18,381	668	27.5	668		3,673	13
14	FENCE			1998	2,350	156	15	156		1,142	14
15	ASPHALT PAVEMENT			1998	7,491	499	15	499		2,890	15
16	PAVEMENT			1999	4,975	181	27.5	181		807	16
17	INSULATING UNIT			1999	6,991	254	27.5	254		1,133	17
18	WALLCOVERINGS/TILES/BLOCK WALLS/CARPET			1999	126,568	4,602	27.5	4,602		20,518	18
19	AWNINGS			1999	7,939	289	27.5	289		1,288	19
20	CHUTE DOOR, PAINTING & PREP ALL ROOMS/FLR TUB			2000	64,360	2,340	27.5	2,340		8,093	20
21	INSTALLATION OF ALL DRAPERIES FOR 4 FLOORS			2001	7,828	285	27.5	285		712	21
22	PAINT & PREP. ROOMS ON FLOORS 4 AND 5			2001	9,525	346	27.5	346		865	22
23	REPAIR HOLES, STRIP, SEAL CRACKS IN PARKING LOT			2001	5,950	216	27.5	216		540	23
24	INSTALL 41 INSULATING WINDOWS - RESIDENT ROOMS			2001	2,974	108	27.5	108		270	24
25	VCT FLOORING - DINING RM & AMIN CORRIDOR			2001	7,165	261	27.5	261		653	25
26	REPLACE ELEVATOR DOORS			2001	3,742	136	27.5	136		340	26
27	PATCH AND PREP. WALLS AND PAINT ROOMS ON 2ND, 3RD										27
28	AND 4TH FLOORS, SECOND AND 4TH FLOOR CORRIDORS			2002	12,983	3,577	7	511	(3,066)	2,783	28
29	FIRE ALARM - ADD/RELOCATE SMOKE SENSORS			2002	6,027	219	27.5	219		356	29
30	INSTALL RUBBER ROOF WITH HALF INCH INSULATION			2003	12,090	220	27.5	220			30
31	INSTALL VINYL TILES IN SHOWER ROOMS ON THE 5TH FLOOR			2003	4,041	73	27.5	73			31
32	2 PLASTIC LAMINATED & 1 INSULTED METAL STAIRWAY DOOI			2003	3,396	62	27.5	62			32
33	PAINT & PREP. NURSES STATIONS, 4TH FLOOR BATHROOMS, 3RD FLR.										33
34	DOORJAMS, FRAMES & STAIRWELLS, 2ND FLOOR BATHROOMS			2003	9,643	175	27.5	175			34
35	NURSE CALL SYSTEM WITH 24 LITE PANEL, PULL CORD & BED			2003	31,136	475	27.5	566	91		35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38			ADJ TO SL	(2,975)			2,975		38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,457,817	$ 161,340		$ 161,340	$	$ 1,083,211	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 394,690	$ 47,513	$ 34,798	$ (12,715)		$ 159,712	71
72	Current Year Purchases	87,473	49,692	4,374	(45,318)		4,374	72
73	Fully Depreciated Assets	19,911						73
74	RELATED PARTIES	918,000	95,859	95,859			609,410	74
75	TOTALS	$ 1,420,074	$ 193,064	$ 135,031	$ (58,033)		$ 773,496	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,877,891	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 354,404	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 296,371	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (58,033)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,856,707	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 42,657 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE DURANGO	$ 295.13	$ 3,542	17
18	ADMINISTRATIVE	2001 LEXUS RX 300	573.00	6,896	18
19	ADMINISTRATIVE	DODGE PICKUP TRUCK	281.46	3,377	19
20	ADMINISTRATIVE	2004 CHEVY T. BLAZER	742.85	743	20
21	TOTAL		$ #######	$ 14,558	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 275,687	$		$ 275,687	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			55,667			55,667	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			340,195			340,195	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			4,277			4,277	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				190,237		190,237	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, RENTALS, I.V. THERAPY Other (specify):	39-2					43,318		43,318	13
14	TOTAL			$		$ 675,826	$ 233,555		$ 909,381	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 204,562	$ 311,997	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 29,763)	1,963,042	1,963,042	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,530	110,649	6
7	Other Prepaid Expenses	125,255	125,255	7
8	Accounts Receivable (owners or related parties)	213,775	93,701	8
9	Other(specify): ESCROW DEPOSITS		920,319	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,549,164	$ 3,524,963	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		716,400	13
14	Buildings, at Historical Cost		4,059,452	14
15	Leasehold Improvements, at Historical Cost		398,366	15
16	Equipment, at Historical Cost	482,163	1,400,163	16
17	Accumulated Depreciation (book methods)	(359,922)	(2,322,666)	17
18	Deferred Charges	793	155,702	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 123,034	$ 4,407,417	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,672,198	$ 7,932,380	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 180,222	$ 205,443	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	293,342	293,342	28
29	Short-Term Notes Payable	645,955	645,955	29
30	Accrued Salaries Payable	36,893	36,893	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,501	9,501	31
32	Accrued Real Estate Taxes(Sch.IX-B)		70,404	32
33	Accrued Interest Payable	421,117	54,204	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO IDPA	29,790	29,790	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,616,820	$ 1,345,532	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,515,355	1,096,374	39
40	Mortgage Payable		7,399,980	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,515,355	$ 8,496,354	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,132,175	$ 9,841,886	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (6,459,977)	$ (1,909,506)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,672,198	$ 7,932,380	48

*(See instructions.)

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,719,925)	1
2	Restatements (describe):		2
3	**2002 DEPRECIATION ADJ.**	(14,396)	3
4	**ROUNDING**	7	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,734,314)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(725,663)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (725,663)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (6,459,977)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,178,891	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,178,891	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,579	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,579	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,181,470	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,292,427	31
32	Health Care	2,738,703	32
33	General Administration	2,292,818	33
	B. Capital Expense		
34	Ownership	1,563,822	34
	C. Ancillary Expense		
35	Special Cost Centers	909,381	35
36	Provider Participation Fee	109,949	36
	D. Other Expenses (specify):		
37	VENDING COSTS	33	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,907,133	40
41	**Income before Income Taxes (line 30 minus line 40)****	(725,663)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (725,663)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	556	556	$ 16,842	$ 30.29	1
2	Assistant Director of Nursing	1,794	2,023	46,461	22.97	2
3	Registered Nurses	5,519	5,967	147,413	24.70	3
4	Licensed Practical Nurses	51,623	55,514	954,762	17.20	4
5	Nurse Aides & Orderlies	98,628	102,655	988,513	9.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,167	2,357	30,145	12.79	8
9	Activity Director	2,014	2,084	30,364	14.57	9
10	Activity Assistants	7,303	7,802	66,248	8.49	10
11	Social Service Workers	8,668	9,071	128,341	14.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,184	2,427	35,462	14.61	14
15	Cook Helpers/Assistants	26,570	27,786	211,430	7.61	15
16	Dishwashers					16
17	Maintenance Workers	4,143	4,320	63,458	14.69	17
18	Housekeepers	22,896	24,410	247,991	10.16	18
19	Laundry	11,988	12,580	107,016	8.51	19
20	Administrator	2,086	2,326	96,617	41.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,517	12,141	201,971	16.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,790	4,010	48,847	12.18	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	263,446	278,029	$ 3,421,881 *	$ 12.31	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	317	$ 18,727	1-3	35
36	Medical Director	180	38,400	9-3	36
37	Medical Records Consultant	48	2,670	10-3	37
38	Nurse Consultant	383	15,707	10-3	38
39	Pharmacist Consultant	240	1,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	2,844	11-3	44
45	Social Service Consultant	55	3,208	12-3	45
46	Other(specify) ALZHEIMERS	50	2,497	10-3	46
47				10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,321	$ 85,253		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LISA TRUDEAU	ADMIN		$ 96,617
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,617

B. Administrative - Other

Description	Amount
FIRST HEALTH CARE - MANAGEMENT FEE	$ 664,575
TOTAL (agree to Schedule V, line 17, col. 3)	$ 664,575
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		280,596
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 280,596

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,028
Unemployment Compensation Insurance	43,654
FICA Taxes	260,803
Employee Health Insurance	172,557
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	4,683
EMPLOYEE PHYSICAL EXAMS	6,728
PENSION/PROFIT SHARING PLANS	3,974
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 576,427

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	17,335
Health Care Worker Background Check	1,884
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	59,979
TRUST/FRANCHISE/CONTRIB/ETC	1,940
LICENSES & PERMITS	6,898
DUES & SUBSCRIPTIONS	18,256
MGMT CO ALLOCATION	1,612
TRUST/FRANCHISE/CONTRIB/ETC	(1,940)
Less: Public Relations Expense	(22,582)
Non-allowable advertising	(25,782)
Yellow page advertising	(11,615)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 45,985

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	1,857
RELATED PARTY	12,822
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,679

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINT/DECORATING	06/2000	$ 3,437	3	$ 572	$ 1,146	$ 1,146	$ 573	$	$	$	$	$
2	PAINT/DECORATING	06/2001	3,848	3		641	1,283	1,283	641				
3	PAINT/DECORATING	06/2002	2,533	3			423	844	844	422			
4	PAINT/DECORATING	06/2003	2,732	3				455	911	911	455		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 12,550		$ 572	$ 1,787	$ 2,852	$ 3,155	$ 2,396	$ 1,333	$ 455	$	$

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTHCARE ASSOC. - $11995.20**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,195** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **109,949**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees